STATE MEDICAL EXAMINER

MSME

REPORT OF DEATH INVESTIGATION

Central Office Use Only

(Date of Receipt)

(DOD Code)

(COD Code)

(ME Case Number)

DECEDENT: _____
(First Name) (Middle Name) (Last Name) (Jr., Sr., III, etc.)

ADDRESS: _____
(Number & Street or Route, Box No.) (City, State) (County)

INFORMATION ABOUT DECEDENT AND DESCRIPTION OF BODY

AGE (If less than 2 yrs. give months & days)

Date of Birth ___/___/___

MARITAL STATUS
- ☐ Married
- ☐ Never Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Unknown

RACE
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Other

SEX
- ☐ Male
- ☐ Female
- ☐ Undetermined

HEAD-HAIR
- ☐ None
- ☐ Partly Bald
- ☐ Blonde
- ☐ Brown
- ☐ Red
- ☐ Black
- ☐ Grey
- ☐ White

OTHER HAIR
- ☐ Mustache
- ☐ Beard

CLOTHING
- ☐ Clothed
- ☐ Partly Clothed
- ☐ Unclothed

EYES:
Color _____

R _____ L _____

WEIGHT:

_____

LENGTH:

_____

MISCELLANEOUS:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ Circumcised

BODY TEMPERATURE
- ☐ Warm
- ☐ Cool
- ☐ Cold _____ (if taken)

RIGOR
(Circle Degree)
- ☐ Neck 0 1+ 2+ 3+
- ☐ Arms 0 1+ 2+ 3+
- ☐ Legs 0 1+ 2+ 3+

LIVOR
Color _____
Fixed? ☐ Yes ☐ No
- ☐ Anterior
- ☐ Posterior
- ☐ Lateral

BLOOD
- ☐ Nose
- ☐ Mouth
- ☐ Ears
- ☐ Clothing
- ☐ None

FROTH
- ☐ Present
- ☐ Absent

OTHER
(Dirt, water, etc.)
- ☐ Nose
- ☐ Mouth
- ☐ Ears
- ☐ None

DECOMPOSITION
- ☐ Early
- ☐ Advanced
- ☐ None

OCCUPATION
(Please fill in both parts)

TYPE OF WORK:

_____
(Example: machinist, typists, fireman, farmer, salesman, homemaker)

INDUSTRY:

_____
(Example: textile, banking, fire dept., farming, insurance, home)

☐ No Occupational Information

INFORMATION ABOUT OCCURRENCE

ITEM	DATE	TIME	LOCATION	COUNTY	TYPE OF PREMISES (Home, farm, highway, hospital, etc.)
INJURY OR ONSET OF ILLNESS					ON THE JOB? ☐ YES ☐ NO
LAST SEEN ALIVE			(By whom: Name and Address)		
DEATH					
FOUND DEAD BY			(By whom: Name and Address or Title)		
POLICE NOTIFIED			POLICE AGENCY:		OFFICER:
CORONER/M.E. NOTIFIED			(By whom: Name and Address)		
VIEW OF BODY					☐ NOT VIEWED
WITNESS TO INJURY OR ILLNESS AND DEATH			(Name) (Address)		**BLOOD SAMPLE DRAWN:** ☐ Yes ☐ Why not?: _____

MANNER OF DEATH

☐ NATURAL ☐ HOMICIDE ☐ ACCIDENT ☐ SUICIDE ☐ UNKNOWN ☐ PENDING _____

MEDICO-LEGAL AUTOPSY AUTHORIZED:

☐ Yes ☐ No

PATHOLOGIST:

_____

OTHER AUTOPSY DONE:

☐ Yes ☐ No

PROBABLE CAUSE OF DEATH:

1. _____

2. Due to: _____

Contributing factor: _____

M.S.M.E. _____

I hereby certify that after receiving notice of the death described herein I took charge of the body and made inquiries regarding the cause of death in accordance with the Mississippi Code Annotated, and that the information contained herein regarding such death is true and correct to the best of my knowledge and belief.

_____
(Signature of Coroner or Medical Examiner)

_____ (Date Signed) _____ (County) _____ (Your Number)

****IS DECEDENT AN ORGAN DONOR? ____YES ____NO (Please ask family when at all possible)

____ KIDNEY ____ EYE ____ ANY NEEDED ORGAN

IF DONOR, DID YOU NOTIFY TRANSPLANT TEAM? ____YES ____NO IF NO, WHO DID? _____

ME-1

Send original to the State Medical Examiner. Copies must be forwarded to County Clerk of Court.

REASON FOR ASSUMING MEDICAL EXAMINER JURISDICTION (Check ONE only)

☐ HOMICIDE	☐ ACCIDENT	☐ POISONING	☐ POLICE CUSTODY	☐ PUBLIC HEALTH	☐ SURGICAL/ANESTHETIC
☐ SUICIDE	☐ DISASTER	☐ UNKNOWN OR	☐ STATE	HAZARD	PROCEDURE
☐ TRAUMA	☐ VIOLENT	SUSPICIOUS	☐ LOCAL/OTHER	☐ SUDDEN/UNEXPECTED	☐ UNATTENDED

MEANS OF DEATH (Agency or Object)—IF DEATH OTHER THAN NATURAL

IF MOTOR VEHICLE INVOLVED

☐ Driver
☐ Passenger
☐ Pedestrian
☐ Other

☐ Lap Belt Used
☐ Shoulder Belt Used
☐ Crash Helmet Worn

☐ Hit-Run
☐ Non-Highway
_____

☐ Passenger Car ☐ Farm Vehicle
☐ Truck ☐ Other _____
☐ Motorcycle _____
☐ Motorbike _____

IF GUN

☐ Rifle—Cal. _____
☐ Handgun—Cal. _____
☐ Shotgun—Gau. _____
☐ Unknown Type

☐ Stippling ☐ Oblong
☐ Smudging ☐ Stellate
☐ Abrasion Collar ☐ Surg. Treated
☐ Round ☐ Other

LOCATION OF WOUNDS (If no autopsy):

_____ Head	_____ Buttocks	_____ Upper Arms
_____ Neck	_____ Thighs	_____ Lower Arms
_____ Chest	_____ Lower Legs	_____ Hands
_____ Abdomen	_____ Feet	_____ Other

IF INSTRUMENT:
☐ **Blunt**
☐ **Sharp**

What Kind: _____
_____
_____
☐ Unknown Kind

TYPE & LOCATION OF INJURIES:
_____
_____
_____

IF DRUG, POISON, CHEMICAL (Suspected)

☐ Alcohol
☐ Other Drugs, Chemical or Poison (Specify by Name)
☐ Unknown

REMARKS/SYMPTOMS:
_____
_____
_____
_____

☐ Ingested ☐ Topical
☐ Injected ☐ Other
☐ Inhaled ☐ Unknown
_____

MEDICAL HISTORY

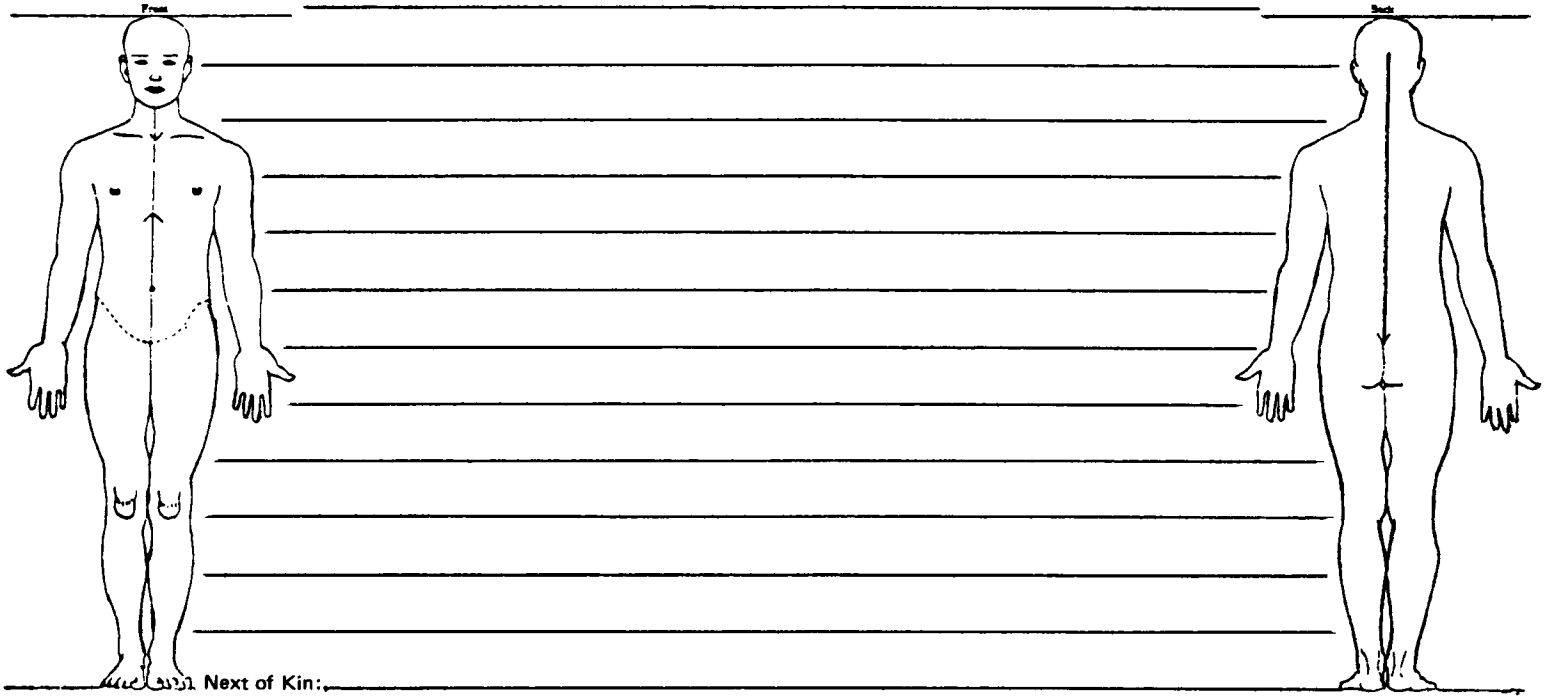
CONDITION:

☐ Alcoholism
☐ Cancer
☐ Diabetes
☐ Drug Abuse
☐ Lung Disease
☐ Fractures
☐ Heart Disease
☐ Seizure (specify)
☐ Other (specify)
_____

DOCTOR: _____
Where treated: _____
Medications: _____

NARRATIVE SUMMARY OF CIRCUMSTANCES SURROUNDING DEATH (Add sheet if needed):

_____
_____
_____



Next of Kin: _____

Funeral Home: _____

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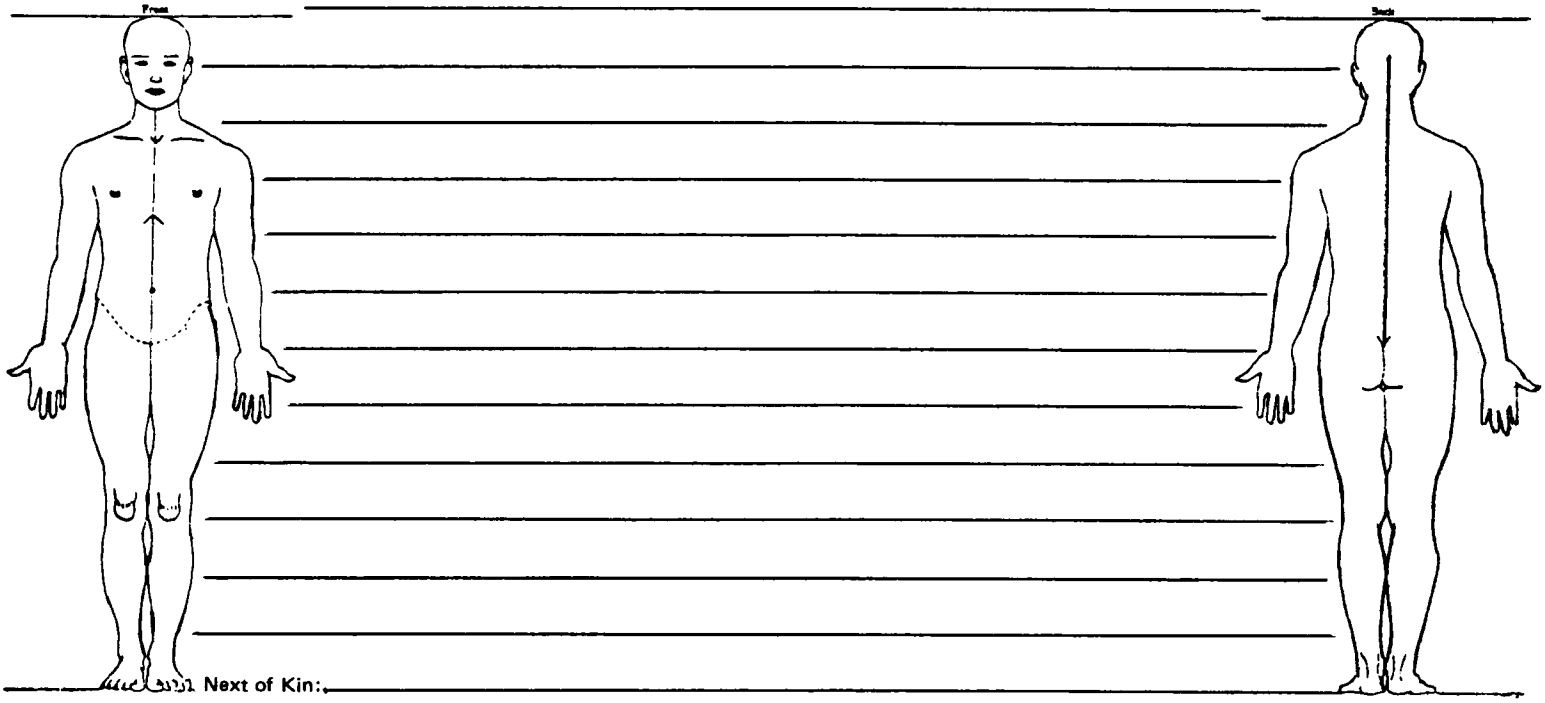

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